**Department of Human Services**
**Bureau of Human Service Licensing**
## LICENSING INSPECTION SUMMARY - PUBLIC

June 8, 2026

[redacted]
CARE HSL NEWTOWN OPCO LLC
[redacted]
C/O HERITAGE SENIOR LIVING
[redacted]

RE: THE BIRCHES AT NEWTOWN
70 DURHAM ROAD
NEWTOWN, PA, 18940
LICENSE/COC#: 14230

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/14/2026, 04/16/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

## Facility Information

**Name**: *THE BIRCHES AT NEWTOWN* **License #**: *14230* **License Expiration**: *09/25/2026*

**Address**: *70 DURHAM ROAD, NEWTOWN, PA 18940*

**County**: *BUCKS* **Region**: *SOUTHEAST*

## Administrator

**Name**: [redacted] **Phone**: [redacted] **Email**: [redacted]

## Legal Entity

**Name**: *CARE HSL NEWTOWN OPCO LLC*

**Address**: [redacted]

**Phone**: [redacted] **Email**: [redacted]

## Certificate(s) of Occupancy

**Type**: *I 2* **Date**: *06/17/2016* **Issued By**: *Newtown Township*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *147* **Waking Staff**: *110*

## Inspection Information

**Type**: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

**Reason**: *Fine* **Exit Conference Date**: *04/16/2026*

## Inspection Dates and Department Representative

*04/14/2026 On Site* [redacted]

*04/16/2026 On Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *120* **Residents Served**: *97*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Daybreak* **Capacity**: *57* **Residents Served**: *44*

### Hospice

**Current Residents**: *13*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0*

**Are 60 Years of Age or Older**: *97*

**Diagnosed with Mental Illness**: *2*

**Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *50*

**Have Physical Disability**: *1*

# Inspections / Reviews

### 04/14/2026 - Partial

**Lead Inspector**: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/15/2026*

## Inspections / Reviews *(continued)*

**05/19/2026 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/05/2026*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/05/2026*

**06/08/2026 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/05/2026*

**Reviewer:** [redacted] **Follow Up Type:** *Not Required*

## 65a - FS Orientation 1st Day

**1. Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

*Staff person A, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.*

*Staff person B, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services until [redacted].*

*Repeated Violation - [redacted] et al., [redacted], et al.*

**Plan of Correction** ***Accept [redacted]J - 05/19/2026)***

*Immediate corrective actions – Staff member A completed the general fire safety training with the Maintenance Director on 5/13/2026. Staff member B completed the fire safety training with the Maintenance Director on 5/15/2026.*

*Additional corrective actions – the executive director re-educated the AED, Memory Care, Director, and the Resident Care Director on 5/13/2026, on DHS regulation 2600.65.a to ensure that all new employees have fire safety training on the first day of hire. The associate executive director will have team members sign off when training is completed. All current employee files will be audited by May 29, 2026 by the AED to ensure they have the FS training completed.*

*Ongoing quality assurance actions- The AED will audit 5% sample of all staff records each month as part of the quality assurance process to ensure all required training is complete and recorded, with the first 5% sample being completed by May 29, 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q2 2026 –April, May, and June-in July 2026.*

**Licensee's Proposed Overall Completion Date:** *05/29/2026*

## 65a FS Orientation 1st Day *(continued)*

***Implemented [redacted] - 06/08/2026)***

## 65d Initial Direct Care Training

**2. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

**Description of Violation**

*Direct care staff person C, hired on [redacted], began providing unsupervised ADL services on [redacted] However, the staff person C did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted].*

*Repeated Violation - [redacted] et al., [redacted], et al.*

**Plan of Correction** ***Accept ([redacted] 05/19/2026)***

*Immediate corrective actions- Staff Person C completed the Direct Care competency test on 3/21/26. A note has been entered into Staff members C file to acknowledge this violation was cited as part of the 4/14/26 inspection.*
*Additional corrective actions - The Executive Director was re-educated the AED on 5/13/2026 on DHS Regulation 2600.65.d to ensure all new employees have direct care training certification and that they have documentation, demonstrating their ability to perform their job duties before providing unsupervised care. The AED will audit all direct care staff employee files to ensure they have a direct care certification and verifying their ability to perform their job duties before working unsupervised, by May 29, 2026*
*Ongoing quality assurance actions: the associate executive director will audit 5% sample of all staff records each month as part of the quality assurance process to ensure all required training is complete and recorded, with the*

## 65d Initial Direct Care Training (continued)

*first 5% sample completed by May, Ongoing compliance will be reviewed at the quarterly meeting, beginning with review of Q2 2026 April, May, and June, in July of 2026.*

**Licensee's Proposed Overall Completion Date:** *05/29/2026*

***Implemented [redacted] - 06/08/2026)***

## 82c - Locking Poisonous Materials

**3. Requirements**

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**Description of Violation**

*Colgate Triple Action and Scope mouthwash, with a manufacturer's label indicating "in case of accidental ingestion, seek professional help or contact the poison control center immediately," were unlocked, unattended, and accessible to residents. Not all the residents of the home, including resident [redacted] have been assessed as capable of recognizing and using poisons safely.*

*Crest Scope, Crest Cavity, and Colgate white, with a manufacturer's label indicating "in case of accidental ingestion, seek professional help or contact the poison control center immediately," were unlocked, unattended, and accessible to residents. Not all the residents of the home, including resident [redacted] have been assessed as capable of recognizing and using poisons safely. The home has boxes under the sink that are locked to store toiletries. The box was unlocked and accessible to all the residents in the memory care.*

*Repeated Violation [redacted], et al., [redacted], et al.*

**Plan of Correction** ***Accept [redacted] 05/19/2026)***

*Immediate Corrective Actions The MCD and RCD rounded all residents' rooms immediately after the violation was identified and removed the poisonous items. All Department Directors were re educated 5/13/26 by the Executive Director. The direct care staff will be re educated by 5/22/26 by the Resident Care Director and Memory Care Director on DHS regulation 2600.82.c to ensure that all poisonous materials shall be kept locked and inaccessible to residents who are unable to safely use or avoid poisonous materials.*
*Additional Corrective Actions The RCD and MCD will audit all resident apartments by 5/15/2026 to ensure all poisonous items are stored appropriately and secured. Then, MCD and/or RCD will audit resident apartments twice a week X 4 weeks to ensure that no poisonous materials are in resident rooms. Weekly audits will end 6/5/26.*
*Ongoing Quality Assurance Actions The Assistant Executive Director, Memory Care Director, and Resident Care Director will each round the community once daily to monitor that all poisonous materials are stored appropriately and secured, beginning 5/13/26. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q2 2026 April, May, and June in July 2026.*
*MCD and RCD are responsible for sustained compliance.*

**Licensee's Proposed Overall Completion Date:** *06/05/2026*

***Implemented [redacted] - 06/08/2026)***

## 125b - Combustible Restrictions

**4. Requirements**

2600.
125.b. Combustible materials shall be inaccessible to residents.

**Description of Violation**

*On [redacted], the can of Lysol in room [redacted] was unlocked, unattended, and accessible to resident [redacted]*

**Plan of Correction** ***Accept ([redacted] - 05/19/2026)***

*Immediate Corrective Actions - The can of Lysol was Immediately removed from room [redacted] on 4/14/26 by the Regional Operations Director. The Memory Care Director, Regional Operations Director, AED and ED inspected all resident assessable areas on 4/14/26 to ensure that there were no combustible items present.*
*Additional Corrective Actions - The Directors were re-educated on 5/13/2026 by the Executive Director on DHS regulation 2600.125b to ensure that there are no combustible materials accessible to residents.*
*The Maintenance Director is responsible for sustained compliance.*
*Ongoing Quality Assurance Actions – The Maintenance Director will inspect all resident accessible areas weekly to ensure that there are no combustible items present. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q2 2026 –April, May, and June-in July 2026.*

**Licensee's Proposed Overall Completion Date:** *06/05/2026*

***Implemented [redacted] - 06/08/2026)***

## 183b - Meds and Syringes Locked

**5. Requirements**

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

*On [redacted], at approximately 1:00 pm, resident [redacted] MiraLAX was unlocked, unattended, and accessible in room [redacted] Per resident [redacted]s support plan dated [redacted], the resident cannot self-administer medication.*

*Repeated Violation - [redacted], et al.[redacted]*

**Plan of Correction** ***Accept [redacted] - 05/19/2026)***

*Immediate Corrective Actions - On 4/14/26, the RDC and MCD rounded residents' rooms; medications were secured/ locked away or removed for resident safety.*
*The Directors were re-educated on 5/13/26 by the Executive Director. The Med Techs will be re-educated by the Resident Care Director by 5/22/2026 on DHS regulations 2600.183b to ensure that prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked.*
*Additional Corrective Actions - The RCD or MCD will audit resident's rooms 3 x weekly for 2 weeks, then 2 x weekly x 2 weeks to ensure medications are kept secure. Audits will be completed by 6/5/26.*
*RCD and MCD are responsible for sustained compliance.*
*Ongoing Quality Assurance Actions – The RCD and MCD will round resident's rooms each week to ensure that medications are secured in resident's rooms who can self-medicate and removed from residents who are unable to self-administer. Ongoing compliance will be reviewed at Quarterly QA Meeting, beginning with a review of Q2 2026 –April, May, and June-in July 2026.*

## *183b - Meds and Syringes Locked (continued)*

**Licensee's Proposed Overall Completion Date:** *06/05/2026*

***Implemented ([redacted] - 06/08/2026)***

## 183e - Storing Medications

**6. Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

*Resident[redacted] blister pack of [redacted] tab was torn on the foil at pill #6, the pill remained inside the packaging.*

*Resident [redacted] blister pack of [redacted] Chew tab was torn on the foil at pill #7, the pill remained inside the packaging.*

*Repeated Violation - [redacted], et al., [redacted], et al.*

**Plan of Correction** ***Accept [redacted] - 05/19/2026)***

*Immediate Corrective Actions - The med punch cards/ medications that were identified with torn backing were wasted at the time of inspection, on 4/14/26.*
*The RCD, MCD, and AED were re-educated on 5/13/26 by the Executive Director and Med Techs will be re-educated by 5/22/26 by the Resident Care Director and the Memory Care Director on DHS regulations 2600.183e to ensure that prescription medications, OTC medications, and CAM will be stored in an organized manner in accordance with the manufacturer's instructions.*
*Additional Corrective Actions - The Med techs will audit Med Carts by 5/15/26, then weekly X 4 weeks, to ensure that medications are stored properly. Audits will be completed by 6/5/2026.*
*RCD is responsible for sustained compliance.*
*Ongoing Quality Assurance Actions – The RCD and Wellness Nurse will review med cart audits each month to ensure that all medications are current. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q2 2026 –April, May, and June-in July 2026.*

**Licensee's Proposed Overall Completion Date:** *06/05/2026*

***Implemented [redacted] 06/08/2026)***

## 225c - Additional Assessment

**7. Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

## 225c - Additional Assessment *(continued)*

**Description of Violation**

*Resident [redacted] most recent assessment was completed on [redacted]*

*Repeated Violation - [redacted], et al.*

**Plan of Correction** ***Accept [redacted] - 05/19/2026)***

*Immediate Corrective Actions – The Resident Care Director will put a note with the RASP in resident [redacted] record by 5/15/26 to acknowledge this violation was cited as part of the 4/14/26 inspection, in the event someone sees it in the future, so they will know it has been cited and addressed. An annual 2026 RASP will be completed by 5/22/2026.*
*Additional Corrective Actions - The Assistant Executive Director, Resident Care Director, and Memory Care Director were re-educated 5/13/2026 by the Executive Director on DHS regulation 2600.225.c to ensure that Residents shall have an additional assessment that is documented on the department assessment form annually.*
*The RCD, and MCD will audit all residents' annual RASPs by 5/29/26, to ensure that the assessments have been completed annually, within 1 year and 15 days of the previous assessment. Any found not to be completed within the required timeline will be completed by 6/5/26, and have a note entered with the RASP in the resident record by 6/5/26 to acknowledge this violation was cited as part of the 4/14/26 inspection, in the event someone sees it in the future, so they will know it has been cited and addressed.*
*MCD and RCD are responsible for sustained compliance.*
*Ongoing Quality Assurance Actions – The RCD or MCD will review all newly admitted residents' support plans each month to ensure that all assessments have been completed within the required timeline. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q2 2026 – April, May, and June -in July 2026.*

**Licensee's Proposed Overall Completion Date:** *06/05/2026*

***Implemented [redacted] - 06/08/2026)***